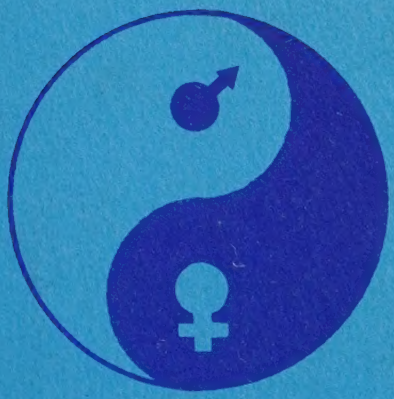

THE LITTLE BLUE BOOK

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Further copies of the 1975 Oxford or general editions of the Little Blue Book are available from the WOLS at a cost of 25p per copy, inclusive of postage. When ordering please specify which edition is required. Cheques or postal orders should be made payable to 'WOLS Committee.'

The WOLS will be pleased to receive any comments or criticism. Correspondence should be addressed to:–

WOLS Committee,
c/o Nick Beeching,
Osler House,
43 Woodstock Road,
OXFORD OX2 6HE.

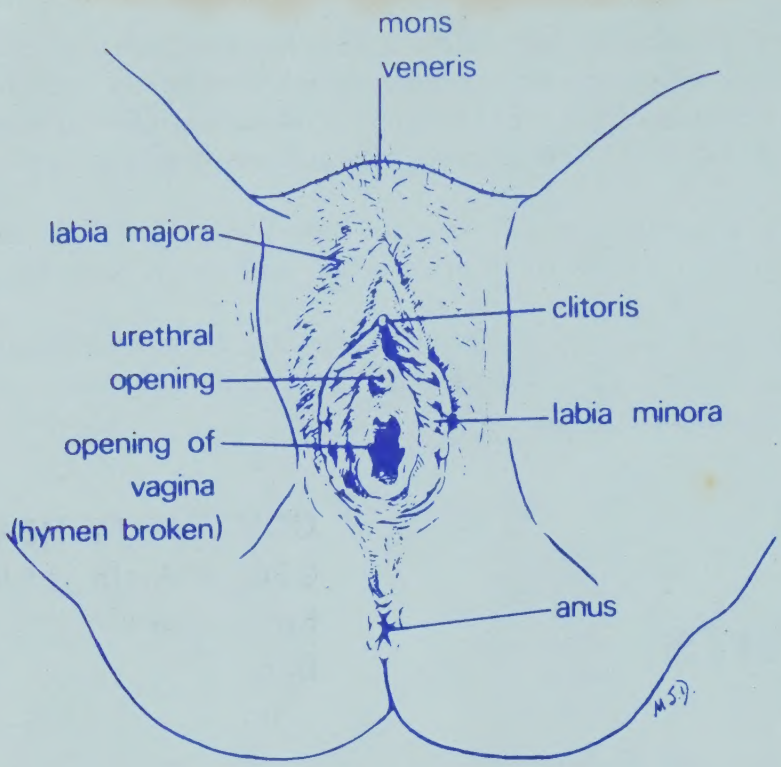
Intr

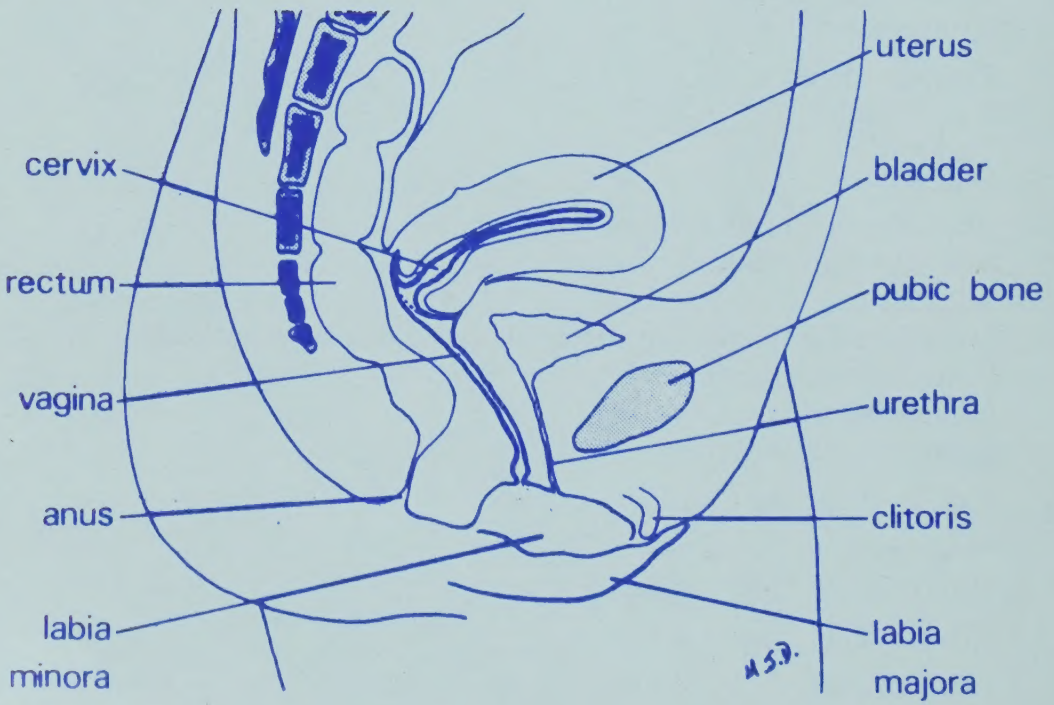
This booklet is about student sexuality, and it has been written by students for students. It includes information specifically relevant to Oxford. We were prompted to write it because it has been estimated that 60% of students who have intercourse take NO contraceptive precautions the first time.

We realise that many students will have no need for this information, but we hope that the content will be of interest to all, and of use to some.

It has been impossible to write without expressing, to some extent, our own moral standpoint. Many will disagree with us; sexuality should be a matter for responsible personal choice.

Contents


mons
veneris
labia majora
clitoris
urethral
opening
labia minora
opening of
vagina
(hymen broken)
anus


uterus
cervix
bladder
rectum
pubic bone
vagina
urethra
anus
clitoris
labia
minora
labia
majora

Anatomy and Physiology

A basic knowledge of sexual anatomy and physiology is a necessary preliminary to a full understanding of the factual content of this booklet.

The Woman

The *vagina* is 4-5 inches long and can easily stretch to accommodate the penis without discomfort. A fluid is secreted which both cleanses the vagina and provides lubrication for the penis during intercourse. The *clitoris* is the female equivalent of the penis, and is usually the woman's most sensitive area.

A little inside the vagina lies the *hymen* (maidenhead). This is a thin membrane which, since it does not completely close the vaginal passage, allows secretions and menstrual blood to escape. It is usually completely broken during the first intercourse, but can also be broken in other ways, such as by exploring fingers.

The two *ovaries* are found in the abdominal cavity, and contain thousands of potential eggs which are already formed at birth. After puberty and until the menopause, one egg is usually released monthly (ovulation) into the abdominal cavity, and passes to the *uterus* (womb) via the *Fallopian tubes.*

Once released the egg has a lifespan of 1-2 days, and, if not fertilized, it simply degenerates and passes out of the vagina.

Hormones and Puberty

Hormones are chemical messengers released into the blood by various glands, which control much of the body's metabolism. In the female, at puberty, the pituitary gland in the brain starts to produce two hormones which cause the ovary to produce two more hormones, oestrogen and progesterone. These initiate the first menstrual cycle (menarche) and cause the physical and mental changes that accompany puberty. In the male, the pituitary hormones cause sperm production and the secretion of the hormone testosterone which is responsible for the male secondary sexual characteristics.

The Menstrual Cycle

The cycle has an average length of 28 days but there is great variation especially in the young. The cycle is controlled by the pituitary hormones and is influenced by physical and emotional stress, often caused by pressure of work, or leaving home. It is common for a large group of women living together, as in a boarding school or women's college, to menstruate at the same time. A combination of these factors often causes the menstrual cycle of female students to be particularly irregular.

The first day of menstruation is taken as day one in the cycle and days are numbered from there to the onset of the next period. The length of the cycle varies but the sequence of physical changes is always the same.

During menstruation which lasts 3-7 days, the spongy lining of the uterus is shed, mainly as a bloody fluid which is heavy at first and gradually lessens. Either an external sanitary towel (ST) or an internal tampon is worn to absorb the fluid. The sanitary towel is held in place between the legs by pants or a belt. Internal tampons are inserted into the vagina and held in place by the elasticity of the walls. An intact hymen is no barrier to using tampons since the small opening in the hymen is wide enough to accommodate them.

Before the onset of menstruation many women feel depressed and can be touchy and sensitive. Once menstruation starts there is often general abdominal pain, back-ache and tender nipples – also a low level of self-confidence and a feeling of lethargy. The severity of the physical and psychological symptoms depends on the individual and nearly all women can cope, with the help of a little sympathy and understanding from friends. If the pain or depression is severe the best thing to do is see your doctor.

The menstrual cycle repeats continuously (unless interrupted by pregnancy) until the menopause. This occurs at some time between 45 and 55 years of age. The activity of the ovaries declines and less oestrogen is produced. Ovulation becomes more and more irregular and finally stops altogether. During this time, women are often depressed and irritable.

Men can go on producing sperm and therefore remain fertile for the rest of their lives although the number of sperm produced gradually falls.

Further Reading

Birth Control by P. Rhodes. Oxford Biology Reader, OUP 1971, 20p.
Short book on anatomy and contraceptive techniques. Very good drawings, scientific approach.

Our bodies, Ourselves – A Book By and For Women by the Boston Women's Health Book Collective. Simon and Schuester, New York 1973, £1.50.
Good general information on all aspects of women's health and sexuality. Men should read it too. Comprehensive bibliography on sexuality and homosexuality on pages 39-41. This book, and those it refers to, may be difficult to find. Try the East Oxford Advertiser, 34 Cowley Road (near the Plain – see map on page 12).

Everywoman by D. Llewellyn-Jones. Faber 1972, 60p.
An excellent account of the sexual life of women. Warm, enthusiastic approach.

The Man

The *penis* is a rod of spongy tissue which during sexual excitement becomes erect due to increased blood flow. Most penises are about the same size when erect (about 5" - 7" long), so the size of the unerect penis is no indication of sexual prowess – neither is the size of the erect penis, since the clitoris lies near the entrance of the vagina, not at its far end. The most sensitive area is the *corona*, the ridge at the base of the *glans penis*, which is covered in uncircumcised men by the *foreskin*.

Sperm are continuously produced in the *testes* from the time of puberty and pass via a mass of tubules up to the *seminal vesicles*. These and other glands, such as the *prostate*, contribute secretions which form the fluid which nourishes and transports the sperm. At orgasm the semen is forced through the *urethra* by rhythmic muscular contractions (ejaculation).

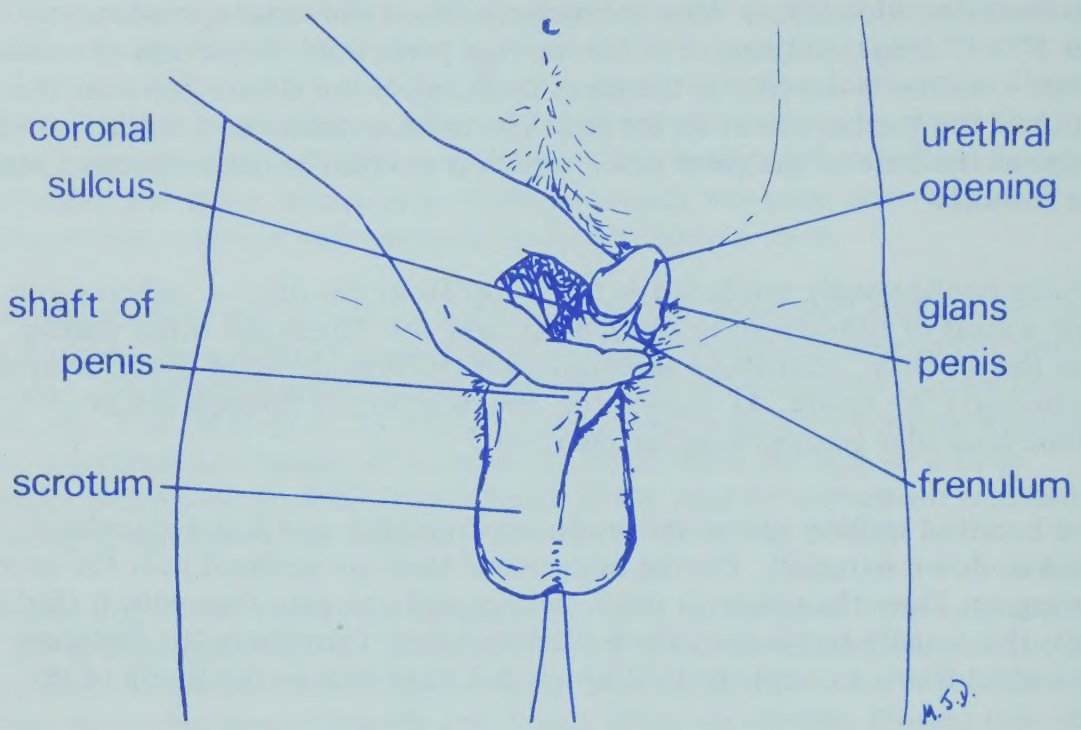
Several hundred million sperm are produced every day and if not ejaculated they are broken down naturally. During intercourse they are released near the *cervix* in the vagina. They then have to reach the egg and one may fuse with it (fertilization): this usually happens in the Fallopian tubes. From here the fertilized egg is wafted down to implant itself about 6-7 days later in the lining of the uterus.

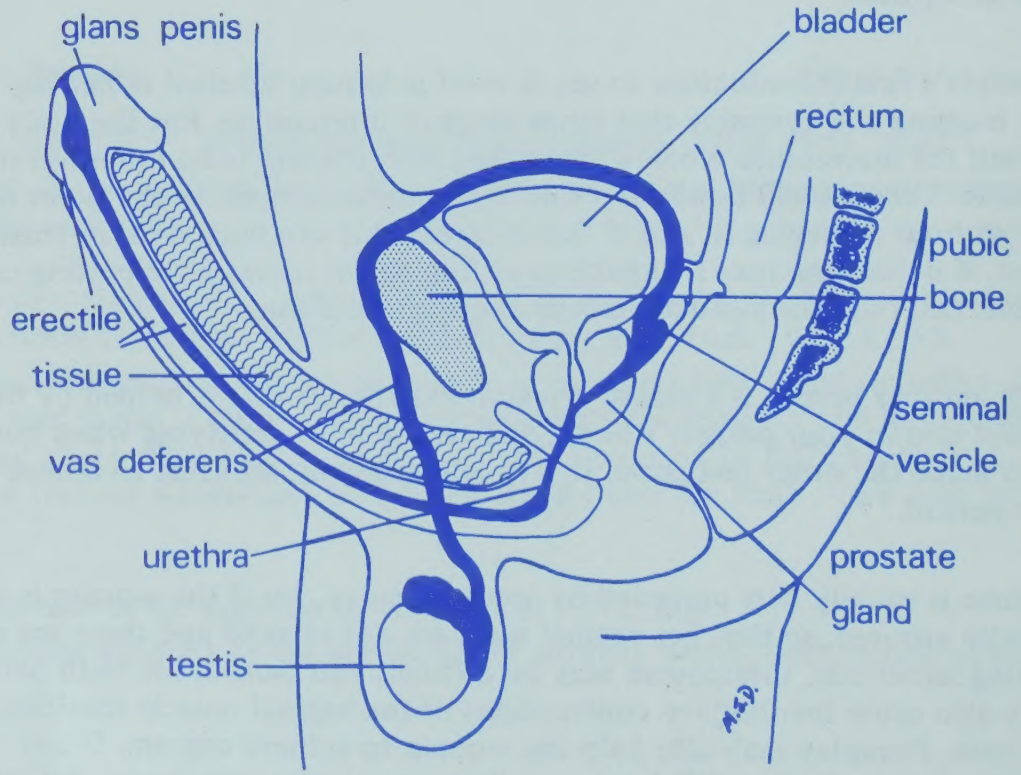
Sexual Response

Most people's first introduction to sex is what is loosely labelled as *petting* – kissing, hugging and caressing that stops short of intercourse. But the body prepares itself for intercourse when it is aroused even if there is no intention to have intercourse. Tension will build up if one is stimulated almost to the point of orgasm without achieving it, and if this is repeated it can become very frustrating. However, if neither partner is expecting or hoping for intercourse petting can be enjoyable; this requires mutual concern and consideration.

Sex with another person is a shared physical experience that is helped by having an interest also in your partner's body, and can be most satisfying when both desire to make the other feel good. It is usually sexually arousing to arouse another person.

Intercourse is usually best preceded by some foreplay, for if the woman is not sufficiently aroused, so that her vaginal walls are not relaxed and there are no lubricating secretions, intercourse may be difficult and painful for both partners, and may also cause involuntary contractions of the vaginal muscle resulting in further pain. Foreplay may also help the woman to achieve orgasm. It can include kissing, stroking and licking, usually concentrating on the genital areas as arousal increases. Arousal causes an increase in breathing and heart rate in both partners, and sometimes also a general flushing of the skin.


coronal
sulcus
shaft of
penis
scrotum
urethral
opening
glans
penis
frenulum


glans penis
bladder
rectum
pubic
bone
erectile
tissue
vas deferens
seminal
vesicle
urethra
prostate
gland
testis

There are many ways to produce orgasms apart from sexual intercourse. Self-masturbation, mutual masturbation and genital-oral contact (for example, the 69 position) can all be satisfying; and as long as there is no mutual genital contact, there is no risk of pregnancy. Even before orgasm the erect penis emits some sperm, so it is not safe to have the penis and vaginal entrance in contact at all without using contraception.

Intercourse itself can be in many positions; it is reckoned that it is probably still most common for the man to be on top, but it has been suggested that if the woman is on top she can more easily attain her orgasm and the man can more easily control his ejaculation. Penetration can be clumsy at first, and may require guidance by the woman. Many women do not reach orgasm as quickly as men, but the man can often carry on after his orgasm, or he can delay it, which may also increase the intensity of his pleasure. Otherwise, gentle clitoral stimulation may produce an orgasm in the woman, though this, if prolonged, can become painful.

However, either partner may not want an orgasm. Simultaneous orgasms are pleasant, though rare; some prefer to enjoy their own and their partner's orgasms separately.

During orgasm in the man the muscles at the base of the penis contract, leading to ejection of the semen, and there are simultaneous contractions of the thigh and hip muscles. Immediately following ejaculation the glans is very sensitive. During orgasm in the woman the muscles of the vagina and uterus contract rythmically. There are varying degrees of orgasm, both in length and depth of sensation, and some people can experience multiple orgasms.

It is perfectly all right to have intercourse during the woman's period, although it is useful to have a towel underneath since there may be some bleeding when the penis is withdrawn. It is often useful to have tissues nearby anyway, since both the vaginal secretions and semen may leak out afterwards.

Further Reading

The Joy of Sex. A gourmet's guide to lovemaking by Alex Comfort. Quartet Books Ltd. £6.50 (hardback), £1.95 (paperback).
The art of making love. Marvellous pictures.

The Book of Love by Dr. David Delvin. New English library 1975, 90p.
Intended primarily for the married, with good pictures.

Sexual Encounters

The previous chapters have given detailed anatomical and physiological views of sex, but these are just the mechanics. The emotional aspects of sexuality are the ones people most often find it hard or embarrassing to talk about, and there is a great shortage of helpful information on the subject. We have included this short chapter outlining some of the problems that may be encountered, and indicating where help can be obtained if required.

There is no norm of sexuality to which one should compare oneself or conform. Its depth and mode of expression vary, as do attitudes and experience and a corresponding range of emotional and sexual needs exists. Attitudes to relationships are likely to change at college because of a different set of influences. Many people come straight from single-sex schools, and have a lingering tendency to view the opposite sex merely as prospective sexual partners, or status symbols, with little or no consideration of them as people.

The fact that few people talk openly and honestly about sexual attitudes leads to many people feeling that every sexual relationship has to involve intercourse, and that there is a stigma attached to virginity. In a recent survey carried out at Aberdeen University, it was found that 56% of unmarried women students had not experienced sexual intercourse. Virginity is not merely a physical state, it is also a part of one's character.

It doesn't seem to be appreciated that remaining a virgin is often a positive choice, rather than the regretted result of lack of opportunity. Many people are happier if they do not rush into complete realization of their own sexuality, which for most is a complex process. The intimacy of lovemaking can be upsetting for someone who is not prepared. True sexual freedom means the right to decide for yourself whether and when you want intercourse.

It would be unfortunate, and certainly not intended, if this book gave anyone the impression that the main criteria for assessing sexual responsibility were the use of contraception and prevention of VD. There is at least one other question to be asked:– 'Will sexual intercourse on this occasion, or with this person, lead to anyone, including myself, being hurt?' It should be borne in mind both what can be gained and what can be lost from a sexual experience. Although sexual attraction probably plays some part in nearly all male-female relationships there may be no physical expression of it.

One of the most frequent forms of sexual expression is *masturbation* (self-induced orgasm). It provides a way of understanding one's own feelings and sensations, but an incredible number of old wives' tales still exist: it won't make you blind or impotent. Nor it is a sign of immaturity – many people who have established satisfying sexual relationships also masturbate periodically, and it can provide a good outlet for the differing sexual drives of the partners.

In fact, the only harm caused by masturbation is psychological, through guilt feelings which may arise for a variety of reasons. For instance, some feel that

any sex is wrong – or that sex is only right as a means of expression between two people. These points are obviously very personal, and the fact remains that there is no physiological reason against masturbation.

Many more people masturbate than might be realized. Almost all men, and three quarters of women, have masturbated by the age of twenty-one. It is a good way to relieve tension, and is especially common among students before exams. Some people feel ashamed and worried about their sexual fantasies, especially those they have while masturbating. These are usually the product of a lively imagination rather than an expression of the sexual experiences one desires to have.

Petting can be a good outlet for sexual feelings without actual intercourse, but since it can be a prelude to intercourse it requires responsibility. Either partner may be greatly aroused and feel frustration at stopping short, especially if it is not mutually understood or believed at the beginning that the petting is not going to lead to intercourse. Petting, as much as intercourse, requires consideration for the other person's feelings.

Sex is often enjoyed at its fullest when both partners are certain of each other's enjoyment and satisfaction. Many women complain of insufficient consideration from the man, and some men become obsessed with the woman's satisfaction and orgasm at the expense of their own pleasure.

Intercourse itself may be a great disappointment the first few times. For instance, the woman may experience pain or possibly a sense of loss, while the man may be afraid of not being able to maintain an erection long enough to permit penetration. Patience, good humour and understanding, especially from the more experienced partner, usually overcome this.

Impotence is a common problem among male students, often caused by worry about the relationship, or about sexual prowess. Nearly all men suffer temporary impotence at some stage of their lives, and feel that this is the end of the world. Alcohol, because of its depressant effect, is a very common cause of temporary impotence. Three forms of impotence are generally recognized: failure to ejaculate is rare in young men. Premature ejaculation is very common, particularly if the man is inexperienced. Erectile impotence is a self-regenerative problem: the anxiety caused by a single failure to erect may cause so much worry that failure to erect occurs on subsequent occasions, with a possible reluctance to risk any more failures. Impotence needs the patience and understanding of both involved in the relationship in order to get out of this sort of vicious circle. Impotence may also be cured by discussion with a doctor or counsellor, who can isolate the underlying causes and help to reduce anxiety.

The female counterpart of impotence is non-arousal. No lubrication of the vaginal walls occurs and this leads to soreness on penetration. A much rarer problem is vaginismus – an involuntary contraction of the muscles around the vaginal opening which makes penetration painful or impossible. This is often associated with guilt or fear. Repugnance or a feeling of insecurity can also prevent a relaxed enjoyment of sex. This can be helped if both partners are aware of these problems and able to talk about them.

This section can do little more than outline some of the common problems it cannot pretend to be an instant counselling service.

Further Reading

Boy Girl – Man Woman by Bent H. Claësson, translated by Christine Hauch. Caldar and Boyars 1971, £1.25.
Written for teenagers, but so frank, sensible and comprehensive that most adults would find it interesting. It is especially good in dealing with almost every sexual problem that anyone could find embarrassing.

Homosexuality

A homosexual is someone who is physically and emotionally attracted to others of her or his own sex. Most people have emotionally close relationships with some of their own sex, and nearly as many as a quarter have or have had some sexual relationship with someone of their own sex: homosexuality may be a possibility in all of us. The point at which we label someone a homosexual is to some extent arbitrary and although whom you love, or have sex with, is important, it is only one aspect of you – it is not what you are. Calling someone a homosexual does not completely define them, any more than classifying someone as a woman tells you everything that they feel or do. At no point in life do you have to decide whether you really are homosexual *or* heterosexual; at no point does an earlier attraction or relationship determine your future.

If we are lucky, our sexuality can be a means of communicating and sharing, of learning to understand and enjoy our own and each other's bodies. Unfortunately, society has a long way to go before recognizing such contact as equally valid whether between people of the same sex or of the opposite sex, and we are all, even those who feel firmly heterosexual, under pressure to devalue, suppress or conceal the homosexual elements of our nature, even to the point of being afraid to show care for people of our own sex. We would all benefit from more tolerance and less stereotyped sexual role-playing.

There are still problems involved in being homosexual, primarily due to the intolerance and discrimination of other people. One is expected to be secretive about feelings, to lie to employers, friends, family, even to oneself. Homosexuals face discrimination in jobs, in their social life and in accommodation. They are taught to see themselves as deviants; they are told they are sick, and are pressurized into trying to be cured.

It is very difficult to 'come out', to start being open and honest about being gay. Many find it valuable to join gay groups where they can meet and talk with other gay people, find out about gay social events, and most important of all, begin to work out their own ideas and uncertainties in a supportive and friendly atmosphere. For many gay people, coming to university or college is an escape from the pressures and expectations of home for the first time. Students tend to be more tolerant and open-minded towards homosexuals than almost any other group, and in university towns there is often quite an open and flourishing

'gay scene', with discos, parties and a variety of different meetings and meeting places. Even so, there can be many problems, of readjustment, uncertainty, and not least the knowledge that they must return to their old environments at the end of term.

Much of the section 'Sexual Encounters' is as relevant to homosexuals as heterosexuals, since forming any satisfactory emotional or physical relationship is always a matter of individual trial and patience, and like heterosexuals, homosexuals may experience a wide range of sexual desires and responses. There are however, certain differences which it is important to point out. Gay men face legal discrimination in that the age of consent is 21, so that any homosexual act involving men under 21 is illegal. Obviously this applies to a very large number of men at university. Above that age homosexual acts (which have in some cases been taken to include even holding hands) are illegal except in private. Anal intercourse, which is illegal between a man and a woman, is, however, legal between consenting men of 21 or over. Gay women are in a very different position since they do not exist in legal terms, and there is no age of consent. They are also considerably luckier than men in that venereal diseases are seldom passed on by contact between women, whereas these can easily be contracted through anal intercourse between men. Anal syphilis is becoming more common, helped by the fact that it is difficult to detect.

There may for various reasons be times when homosexuals require professional guidance, whether medical, psychiatric or legal, over matters which relate specifically to their sexuality, and they may feel diffident about discussing such matters with someone who may be unsympathetic. In such cases it may be helpful to contact one of the gay organizations listed below who would probably be able to suggest the best person to go to.

Further Reading

Homosexuality from the Inside by D. Blamires. Published by the Social Responsibility Council of the Religious Society of Friends, at Friends House, Euston Road, London NW1 2BJ, 1973, 20p.

Well written account of what it is like to be homosexual, and of the attitudes of the general public.

Homosexuality – Time to Tell the Truth by Dr. Leonard Barnett. Victor Gollanz 1975, £1.50.

Attempts to dispel all the myths surrounding homosexuality, and pleads for the acceptance of homosexuals as part of the natural order.

Addresses

Gay Icebreakers ☎ 01-274-9590

A phone service for homosexuals to discuss their problems with other gay people. 7.30 p.m. – 10.30 p.m.

Gay Switchboard ☎ 01-837-7324

24 hour phone service, providing addresses anywhere for legal, counselling medical and other problems.

Contraception

The following pages describe the available contraceptive methods, which differ greatly in their style, effectiveness and associated complications. At the end of the section there is a table of effectiveness and frequency of use of the different methods, and a summary of the arguments for and against each contraceptive.

No contraceptive is absolutely effective, and to make a contraceptive as reliable as possible requires strong motivation to avoid pregnancy. Taking risks and keeping your fingers crossed is not a form of contraception – 80% of women who have regular unprotected intercourse will become pregnant within one year. *It is better not to have intercourse than to run the risk of an unwanted pregnancy.*

Intercourse without contraception

Despite the availability of information on contraception, and the increased ease with which contraceptives can be obtained, many couples still persist in having intercourse without them. There are many reasons for this: probably the most frequent is a lack of awareness of how strong the sexual drive can be, so that neither partner has anticipated or is prepared for intercourse. Another factor in student pregnancy is the refusal to fully recognize the meaning of sexual acts, and to take responsibility for them. Some may subconsciously wish to experience pregnancy as a kind of fulfilment, as an expression of femininity, or as a way of giving meaning to a relationship. Other people coolly maintain that intercourse without contraception is more exciting because it is more dangerous: it is also said that the forethought involved in contraception reduces the romance and spontaneity of the relationship.

If you are in doubt about the need for contraception we can only recommend a careful reading of the sections on abortion, and on the decisions to be faced if an unwanted pregnancy occurs.

The Sheath or Condom (French Letter)

The great popularity of the sheath is reflected in the large number of nicknames and jokes associated with it, and it is the most common form of contraception amongst students. The sheath is easily obtainable, and is convenient for unplanned intercourse which carries the highest risk of pregnancy. Sheaths are usually quoted as having high failure rates. These are generally due to lack of motivation or carelessness on the part of the couple. If they are properly used every time, pregnancies rarely occur.

Use of sheaths

The principle or use of the sheath is simple. The man puts a sheath made of thin latex rubber over his erect penis before intercourse, and this catches the semen on ejaculation so that no sperm can get into the vagina. The sheath should

be put on to the penis before there is any contact between it and the vagina, as a few sperm may be present in the lubricating fluid secreted at the top of the penis prior to intercourse.

Sheaths come in plain or teat-ended varieties. The teat acts as a receptacle for semen; when the sheath is rolled on to the erect penis, the teat, or the end of the sheath, should be pinched to expel any air. After ejaculation the penis should be withdrawn while still erect, and the rim of the sheath held to prevent it from slipping off. As an added precaution against mishaps, the woman is advised to use a spermicide. Once used, a sheath should be thrown away.

Although sheaths are all the same size, they are elastic enough to fit any penis. They are sold ready lubricated, but additional lubrication such as saliva, baby lotion, KY jelly, or spermicides may be used. *Vaseline, petroleum jelly, or oil should not be used as these destroy the rubber.*

Sheaths are tested extensively before being sold, and reliable makes are stamped with the British Standard kite mark, so it is advisable not to test them before use. There are always rumours that sheaths split – but this is a very rare occurrence with reliable makes. Sheaths can be blown off on ejaculation, usually because air has been retained in the end teat if it was not pinched when the sheath was put on. Sheaths are marked with a date after which they should not be used, since the rubber will deteriorate, as it will if kept in warm damp places (such as the back pocket of trousers).

As yet, men cannot obtain free supplies of sheaths from family planning clinics. Women may obtain free supplies from clinics, in situations such as:–
– if they've decided to use sheath with spermicide.
– in the first 14 days of taking the pill.
– during instruction in the use of the cap.
– when deciding between using a particular contraceptive method.
– on changing brands of pills.
– when pills are forgotten.
– following childbirth when use of the cap is unsuitable.

Discussion

The only medical problem associated with the sheath is that either partner may be allergic to the rubber or lubricant and develop a rash. For some the sheath reduces pleasure in intercourse, although possible reduction in sensitivity has the advantage of delaying the man's orgasm; and for others it is an unwelcome interruption, though it can be incorporated into foreplay.

The sheath is the man's responsibility and men have less motivation to prevent pregnancy, as it is not they who become pregnant. It is very easy to be without a sheath when one is needed, or to be too lazy to use them during repeated intercourse.

No medical supervision is needed for the sheath and less mess and fuss are involved compared to other mechanical forms of contraception. It is the most popular form of contraception due to its ready availability and ease of use. It

also affords considerable protection against VD. For effective contraception the sheath must be used *every* time. Perhaps the greatest argument in its favour is its convenience for unplanned intercourse, which carries the highest risk of pregnancy.

Price and Availability of Condoms

Condoms can be bought easily from all chemists and may be obtained more cheaply through mail order firms. Addresses of some of these are included below:

Lamberts (Dalston),
200/2 Queensbridge Road,
London E8.

Phelps Surgical Appliances,
P.O. Box 42,
165 High Road,
London N15 5PG.

Lloyds,
51 Albert Road,
Southsea,
Portsmouth PO5 2SF

Le Brasseur,
1 Bristol Street,
Birmingham.

Premier Laboratories,
11 Black Lion Street,
Brighton.

Ann Summers Sales Ltd.,
12 High Street,
Caterham,
Surrey.

The Pill

The pill is the most effective form of reversible contraception and it has to be obtained through your doctor or one of the family planning clinics (see page 34). A lot of information is given here concerning the pill, both because it is so widely used, and because there has been so much controversy over its problems.

How the pill works

Two types of pill are generally prescribed. The combined type contains the synthetic chemicals progestogen and oestrogen, similar to the hormones naturally occurring in the body; the 'mini-pill' contains only progestogen.

Most of the side-effects of the pill are connected with its oestrogen content, which has been considerably reduced in the newer pills. Both oestrogen and progestogen work together to prevent ovulation. Progestogen given alone does not regularly prevent ovulation, but it has other contraceptive effects: in particular it thickens and alters the cervical mucus so that sperm cannot pass through, and it changes the uterine lining so that it will not receive the egg if it is fertilized.

Periods and the pill

Progestogen prevents the womb lining from becoming overgrown and therefore a woman taking the pill not only has a regular cycle but often a lighter menstrual flow. In addition the pill can relieve pre-menstrual tension, mid-cycle pain and the incidence of anaemia. For some women there is a delay before their periods start again after they stop using the pill. The delay is not related to the length of time the pill has been used, and is usually only for a month or two. Occasionally it persists beyond six months, but this problem usually responds to treatment.

Use

An instruction sheet is given with each pack of combined pills, and your doctor should also give advice; do not be afraid to ask him for more information if the instruction sheet is inadequate. Packs contain 21 or 22 pills, depending on the brand. The first day of the period is counted as day 1, and the first tablet is taken on day 5 whether bleeding has stopped or not. The remaining tablets are taken daily, followed by seven or six tablet-free days respectively, during which time the period will occur. The next course of pills is then started.

You must wait 14 days after first taking the pill before effective contraception is guaranteed, and so for this time an alternative form of contraception must be used. You will not ovulate during the tablet-free days and so cannot become pregnant during this time.

If for some reason (for example, at exam time) you want to postpone your period it is safe to lengthen the course of pills for one or two days, although this should not be done often. *After 7 tablet-free days*, during which menstruation will occur, the next course is commenced as usual.

Menstruation usually starts 3-5 days after the last pill was taken. This sort of schedule results in a menstrual flow occurring approximately every 28 days. Sometimes however, menstruation does not occur within the 7 days after the last pill. If this happens to you, don't panic – it is not necessarily an indication of pregnancy, and you should start the next month's pills as usual. If you have any reason to believe you might be pregnant or if you miss two consecutive periods you should go and see your doctor.

It is important to remember to take the pill at about the same time each day, as this ensures a constant level of chemicals in the blood. This is necessary to maintain contraceptive effectiveness. It is also harder to forget to take the pill if this becomes part of a daily routine. Many women prefer to take the combined pill before going to bed as this reduces any chance of nausea.

Missing a pill

It is advisable to have a spare pack handy, in case it is necessary to take another tablet, or if the original pack is lost. If a tablet is missed, one should be taken as soon as possible, even if it means taking two pills on the same day. Then continue with the pills as usual, thus ensuring that the last pill of the cycle finishes on the usual day. Unfortunately, missing a tablet for more than 12 hours may lead to ovulation if the pill contains 0.03 mg of oestrogen. If the pill contains 0.05 mg, the safety margin is nearer 24 hours. IT IS THUS ESSENTIAL that another form of contraception be used for the remainder of the course, as well as taking the pill. Then once bleeding has started you will be safe and there is no need to continue to use contraceptive precautions at this time.

If you are sick within an hour of taking a tablet, you should take an additional one, as the first may not have been completely digested. If you suffer from diarrhoea and vomiting for several days, it is necessary to use another form of contraception for the rest of the cycle and the first week of the next pack.

Pregnancy and the pill

Pregnancy is only likely to happen if the pill is not taken as described and no other form of contraception is used. Once pregnancy is suspected you should stop taking the pill immediately, and go and see your doctor. You should use another form of contraception in case it is a false alarm. It is not considered harmful to take the pill whilst still breast feeding because, although it may reduce the amount of milk produced, this slight reduction will not harm the child.

Minor Problems

A variety of problems are associated with the pill. Nausea, similar to morning sickness, is the most frequent symptom. Breast enlargement and change in weight are common side-effects, as is depression during the first cycle of taking the pill. Some women experience irregular bleeding or spotting, increased vaginal discharge, headache, dizziness or backache. These side-effects can often be reduced by taking a different brand of pill.

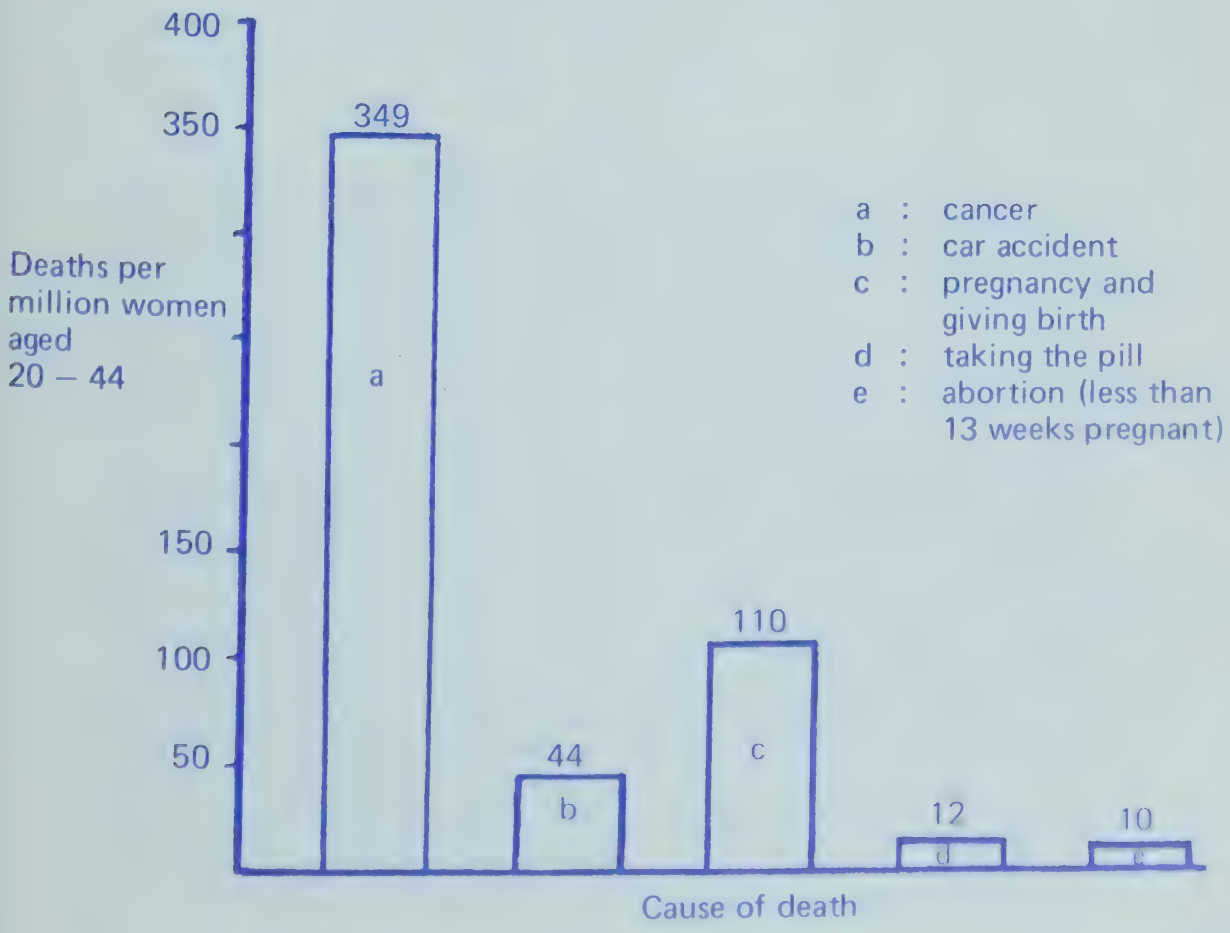
It has been suggested that these problems are equally common amongst women who are not taking the pill: certainly, if the doctor and/or patient is opposed to the pill, problems encountered will tend to be blamed on it. Many side effects wear off after a few months' use, so it is often worth persevering.

The pill may lead to body changes that result in a higher blood pressure. The doctor should check the blood pressure at regular intervals and note any changes.

Major Complications

One such problem is thrombosis – a condition in which a blood clot forms in a blood vessel. It has been suggested that the combined pill increases the risk of thrombosis. Among young women not taking the pill, two or three per million will die of this disease each year. The combined pill may cause the death of about another six per million. The risk is extremely small, as is borne out by the figure below which compares other causes of death among women aged 20 - 44. A figure of 12 deaths per million women taking the pill is given, as the risk of death from thrombosis increases with age. The likelihood of thrombosis does not increase with prolonged use of the pill.

People are often worried that the pill might cause cancer to date the balance of evidence shows that the pill does not cause cancer, even of the breast, womb, or cervix. In fact the pill seems to have a protective action against some mild breast diseases.



When it is advisable NOT to take the pill

There are some medical conditions which may cause your doctor to advise against prescribing the pill. Suitable alternatives can be suggested.

You should not take the pill:

Four weeks either side of an operation, although it is recommended for use immediately after an abortion.

– Until any recent liver diseases are fully cleared up.

– If there has been clotting in an artery or vein.

Many doctors are cautious about prescribing the pill for young women who have infrequent periods.

There are other conditions which your doctor will have to consider carefully before prescribing the pill so it is important to let him know of any serious or hereditary diseases that you or members of your family have had.

The Progestogen Only Pill (Mini-Pill)

Mini-pills come in packets of 28 or 42. One is taken on the first day of menstruation, and they are then taken daily, even during periods. The mini-pill is best taken early in the evening as it takes several hours for maximum contraceptive effect to develop (assuming that most people will want to have sex late in the evening). The mini-pill is largely free from the side-effects that are associated with the combined pill, since it lacks the oestrogen component. It is not associated with thrombosis. The main disadvantage is its tendency to disrupt the normal pattern of periods, producing irregular or breakthrough bleeding. The mini-pill is less effective than the combined pill, though it is as effective as most other reliable forms of contraception.

When pregnancies do occur, ectopic pregnancies (when the egg implants elsewhere than in the uterus) are relatively more common than normal: if you suspect pregnancy, you should go and see your doctor.

Summary

The combined pill is a very effective contraceptive, and many women report increased sexual enjoyment because they are free from the worry of pregnancy. A recent very extensive study suggests that the pill causes *no* increase in the number of illnesses among users, and has a number of positive benefits. However, the pill causes very many metabolic changes, the long-term effects of which remain unknown. The mini-pill is less effective, but has fewer of the side-effects associated with the oestrogen in the combined pill.

The IUD ('Coil' or 'Loop')

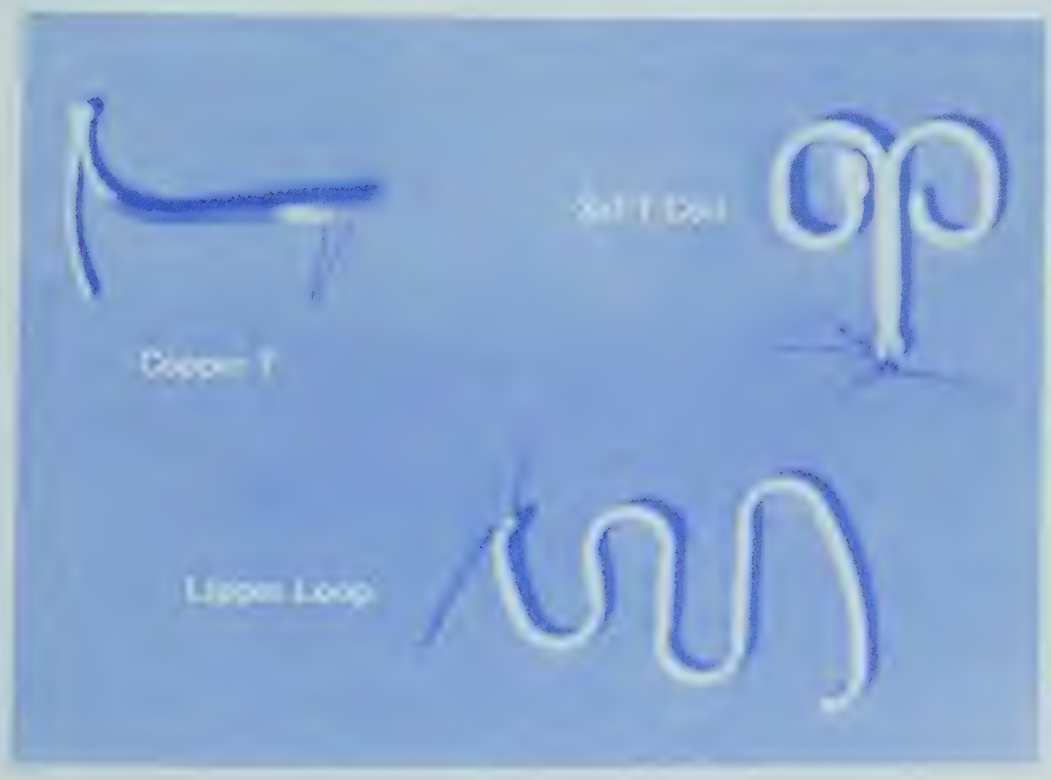
Saharan nomads are said to have put pebbles inside the wombs of female camels to stop them becoming pregnant while on long desert journeys. The modern intra-uterine device (IUD) is a small plastic object that is placed in the uterus to prevent pregnancy. There are two kinds of IUD: some are unsuitable for insertion into young women who have not had children, as they may cause pain on insertion, distort the womb and easily fall out. More modern IUDs such as the Copper 7 have been designed for young women who have not had a child.

Fitting the IUD

Family planning clinic doctors, and some in general practice, will fit the IUD. The best time for insertion is during the last few days of menstruation or the following three of four days. This is for two reasons: firstly it is the time of the month when the cervix is most dilated, and secondly the period means that the woman is not pregnant. The doctor will give a complete pelvic examination, checking the vagina and womb for disease, and then the shape, position and size of the womb and cervix. If the doctor finds pelvic infection, or if periods have been heavy or irregular, appropriate treatment may be necessary before insertion, or an alternative contraceptive method advised.

The device is first placed inside an introducer, which is inserted through the cervix into the womb cavity, where the device is released. Many women are worried about pain at the time of insertion. A study of the newer devices showed that 88% of young girls using them felt no pain at the time of insertion.

Some IUDs, life-size



The rest felt some pain in the form of cramps for a few minutes. The doctor will let the woman lie still for five or ten minutes after insertion, in case of cramps, and if she feels pain (or is worried that she might do so), a pain-killing injection is given. After insertion there will probably be some vaginal bleeding for a day or two, during which it is safe to wear an internal tampon. There might also be a little vaginal discharge during the month following insertion.

A thread hangs from the IUD into the upper part of the vagina, which can be felt, as shown by the doctor. This should be done once a month, the best time being after menstruation. If the thread is not there, it may be coiled inside the womb or the IUD may have fallen out, and a return to the clinic is necessary. Because the IUD may have fallen out other contraceptive methods must be used until the device has been replaced. The IUD may be partially expelled, in which case when checking for the thread a hard knob like the end of a matchstick is felt. A return to the doctor is necessary, and other contraceptive methods must be used.

How the IUD works

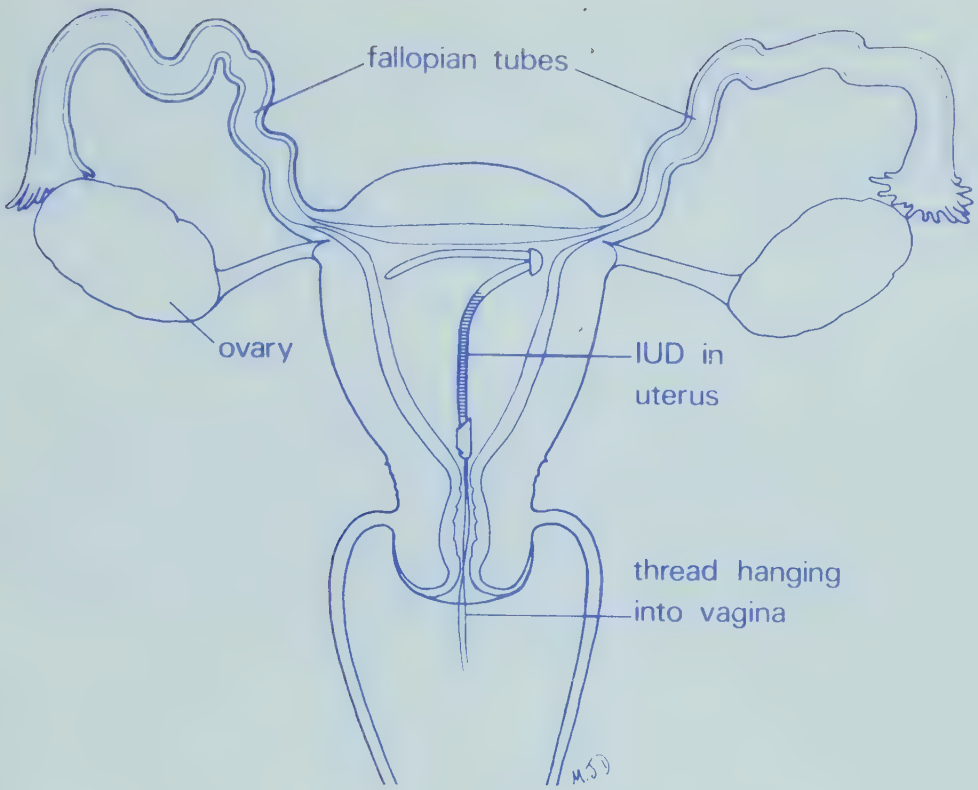
It is thought that the IUD causes production of cells which may destroy the sperm and interfere with the process of implantation of the ovum into the lining of the uterus. In copper IUDs the copper itself probably stops pregnancy by a similar process, in addition to making the womb environment hostile to conception. Highest concentrations are released during the first few months – a time when other IUDs are least effective. As the copper is released the device will need to be replaced once every three years.

A recent study concludes that the Copper 7, although a better IUD for women who have not had children, is not significantly better than the other devices it has tended to replace.

Minor problems with the IUD

The most common problem is abnormal vaginal bleeding, which may be irregular and involve particularly heavy menstruation, especially for the first few periods after insertion. The problem tends to disappear of its own accord after a few months, although it may recur at a later date. If it persists the doctor should be seen.

Pain in the form of uterine cramps, or low backache is another common problem, which normally clears up after a few months. A third problem is that IUDs may be expelled from the womb, an event which is most likely to happen in the month after insertion, especially during menstruation. After a few months the chances of expulsion drop rapidly. The most common reasons for women having the IUD removed are bleeding and pain.



Major problems with the IUD

These are very rare. The IUD may break through the wall of the uterus and come to lie in the body cavity. This is very unlikely to happen, and if it does so, the device is normally removed. Infection may happen and is often a recurrence of a previous infection which usually clears up with antibiotics, and the device may or may not be removed. the IUD does not cause cancer and is unlikely to reduce the chances of pregnancy once removed.

There is no evidence that the copper IUDs cause cancer or are poisonous. The copper does not reduce the chance of becoming pregnant once the device is removed, nor does it appear to harm the foetus if pregnancy occurs while the device is still in position.

Effectiveness of the IUD

The IUD has a low pregnancy rate, although this is higher in the first year of use. Most pregnancies occur with the device still in place. Here no harm can come to the baby. Ectopic pregnancies (when the egg implants elsewhere than in the uterus) are relatively more common than normal: if you suspect pregnancy you should go and see your doctor. The IUD usually falls out at birth.

Summary

A good measure of the acceptability of the IUD is how long women continue to use it. Studies show that for women of student age, over three quarters still use copper IUDs after one year.

The Diaphragm and Spermicides

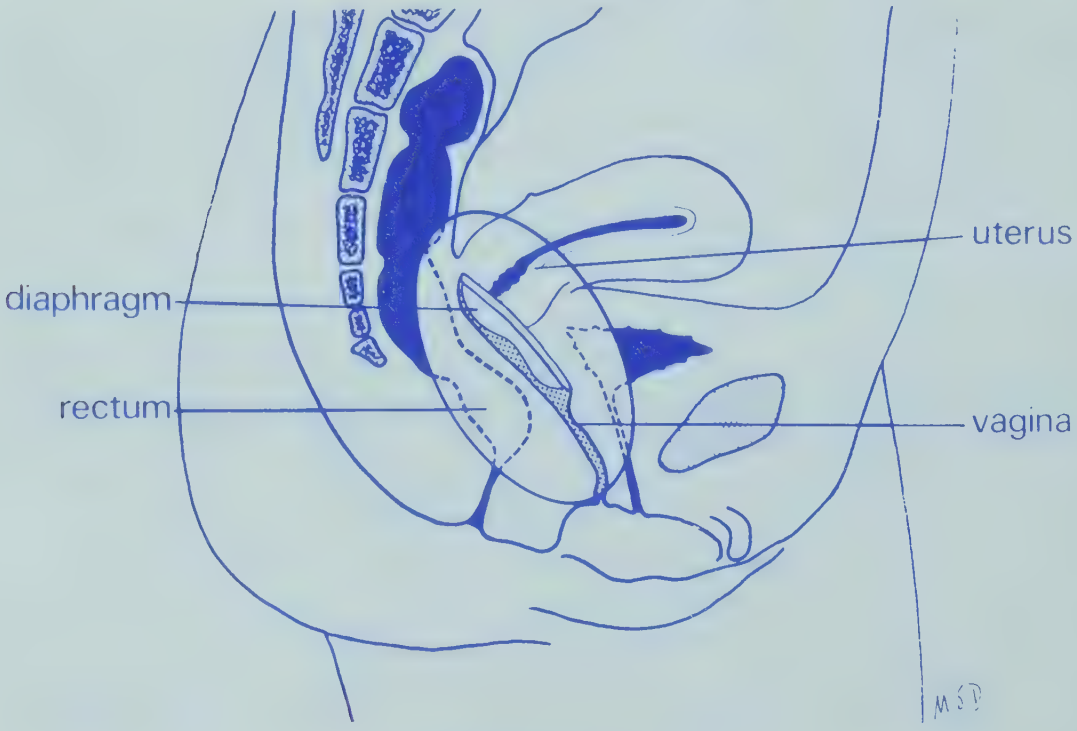
Caps and diaphragms are mechanical barriers which block the passage of sperm into the uterus. They should always be used with a spermicide. Spermicides, although now recognized as an independent form of contraception, are not recommended for use alone by women who cannot afford pregnancy.

Types of Cap

There are three main types: the diaphragm (dutch cap), the vault cap and the cervical cap. They all fit in the vagina over the cervix to shut off the entrance to the womb. The dutch cap is the largest of the three and probably the easiest for most women to use. It is made of thin rubber in the form of a dome, the rim of which contains a metal spring. The diaphragm comes in ten different sizes, so the correct individual size can be found. The cervical caps are smaller and look rather like bowler hats which fit snugly over the neck of the womb. These come in four sizes. The vault caps are rubber or plastic domes, and are more rigid than the other types.

Fitting the Cap

The doctor will check the size and position of the vagina and uterus and discuss which is the most suitable cap to fit, and will then teach insertion and removal of the cap. The diaphragm is put into the vagina by being squeezed into a long oval and then pushed along as far as it will go until its back end slides beyond the neck of the womb. The front end is then pushed up to lie behind the pubic bone. The diaphragm spring regains its circular shape when released and presses against the wall of the vagina on all sides. The doctor will show how to check that the diaphragm is correctly placed, by feeling the knob of the cervix



Diaphragm in place

through the thin rubber dome. This is more difficult than it sounds, especially with short fingers. Regular check-ups with the doctor are essential. The cap is only effective when fitted accurately, and a new cap should usually be obtained every 9 or 12 months. A change in the size of cap required may occur after any of the following:

– A change of weight of 10 lbs of more
– Intercourse after a long period of abstinence
– A pelvic operation
– Giving birth.

Use of the cap

When fitted properly neither partner should be able to feel the diaphragm during intercourse; this is not true of the vault and cervical caps, which the man may be able to feel. As sperm can often seep round the rim of the cap, it is essential to use a spermicide. Tubed products are the ones to use and 2-4 inches of cream or jelly should be divided between both sides of the cap.

The cap and spermicide should be placed in the vagina, no more than two hours before intercourse, and if the time is longer more spermicide should be used. The cap must be left in place for a least six hours after intercourse to ensure that all the sperm are dead. It should not be left there for more than 24 hours without being removed for cleaning.

If pain occurs when the cap is left in place for the six hours after intercourse, this often means that the cap is of incorrect size or excessive spring tension. A visit to the doctor for a new cap is necessary.

It does not matter if a period starts while the cap is still in place, as the blood will trickle past the rim. A pad should be worn in the ordinary way but the cap must be left in for the full six hours. It is better not to use an internal tampon until the cap has been removed. It is safe to walk about with the cap in place, but its fit should be checked before further intercourse.

Once removed the cap should be washed in warm soapy water, rinsed thoroughly, dried and powdered with a powder free from oil, such as unscented baby talc. The cap should be kept away from carbolic soaps, disinfectants, and detergents as these will destroy the rubber. It should be stored in a dry, cool place away from direct light, in the container provided and should be regularly checked for holes. This is easily done by holding it up to the light. It should not be stretched with fingernails and the rim of the diaphragm should be kept circular.

Considerations

The cap should not be borrowed from or lent to a friend, or used without proper medical training. The cap is only effective when the correct size is fitted. A few women are allergic to the rubber (a plastic cap can be used if allergy occurs) but apart from that, the method is free from side-effects. The greatest drawback is one of inconvenience – not being there when needed. To some it is an unwelcome interruption of the spontaneity of making love. It is a valuable form of contraception for women who prefer a more direct control.

Spermicides

There are 3 types of these chemicals: foams which are put into the vagina with the aid of an applicator; tubes of creams, pastes and jellies for which an applicator is also used; foaming tablets and pessaries which release the spermicide when placed inside the vagina. They can all be obtained free of charge from family planning clinics, or bought from chemists.

Foams and tubed products

These are intended for use with caps or condoms. Another application is necessary either if the woman gets up and moves about after the first application or if intercourse is repeated. In these cases the cap must not be removed and the cream or foam should be inserted with the use of an applicator. If condoms are used, the woman can put cream or foam into her vagina just before intercourse. Foams, creams and jellies are harmless, other than occasional soreness or itchiness – if this occurs a change of brand is often all that is needed. They have an unpleasant taste and can be messy.

Foaming Tablets and Pessaries

The instructions which come with tablets suggest that they can be safely used on their own. This is not true. They are quicker and easier to use than creams and jellies – for example for use with a condom, or as a second dose of spermicide with a cap. Tablets should be pushed as far as possible into the vagina, when lying down. As foaming tablets start foaming at once and subside after about 15 minutes, they should be put in just before insertion of the penis. Pessaries take longer to melt, and so should be put in about 15 minutes before. Foaming tablets will only give protection for about 15 minutes, pessaries for about half an hour. They may both cause vaginal irritation. They are the least effective spermicides, and deteriorate quickly in damp or hot places.

The 'C'-Film

This has a spermicide incorporated into a soluble plastic film and is a fairly new type of chemical contraceptive. It is expensive and is advertised as 'a contraceptive unlike any other'. This is certainly true as it is very unreliable. The FPA recommend that it should not be used at all.

Approximate costs of spermicides at a chemist's

Foams cost about £1.50 for an applicator pack, containing a tube of 45 gram weight, which will give about 30 applications. Refills range from 90p to £1.80. Applicators can be bought alone for 20-30p. Tubes of spermicide creams cost about 60p for a 70g tube. This will give about 35 applications. Smaller or larger tubes can be bought. Applicators cost 15 to 35p. Suppositories cost 40p for 12.

The Rhythm Method (Safe Period)

For the majority of students, the rhythm method should not be used. Although it is a recognized form of birth control, it has a high risk of pregnancy. The method is described because there are some who for personal reasons do not wish to use other contraceptive methods. The rhythm method should preferably be used under a doctor's guidance.

To work out the days during the menstrual cycle when pregnancy is likely requires great perseverance and a good head for figures. The time between menstruation and the next ovulation is very irregular, so it is impossible to predict when ovulation will occur. The best method is to use the latest 8 or 12 cycles for the calculation each month. The first day of menstrual bleeding is taken as day one, and the day before the next bleeding starts as the last day. The egg can survive up to three days and the sperm up to four days. The unsafe time in the cycle is taken to be between 11 and 18 days before the next period begins.

Because cycles are so variable in length, the first unsafe day is obtained by deducting 18 from the number of days in the shortest of the last 12 cycles, and the last unsafe day by deducting 11 from the number of days in the longest cycle of the 12. For example, if the shortest of the last twelve cycles is 25 days and the longest 31 days, then the calculation is: 25 – 18 = 7 and 31 – 11 = 20. Thus it is possible to become pregnant on days 7 to 20 of the next cycle. The 'safe' days in any cycle are thus from day 1 to day 6 and 21 to the end of the

Length of shortest cycle in days	First unsafe day after start of any period	Length of longest cycle in days	Last unsafe day after start of any period
21	3rd	21	10th
22	4th	22	11th
23	5th	23	12th
24	6th	24	13th
25	7th	25	14th
26	8th	26	15th
27	9th	27	16th
28	10th	28	17th
29	11th	29	18th
30	12th	30	19th
31	13th	31	20th
32	14th	32	21st
33	15th	33	22nd
34	16th	34	23rd
35	17th	35	24th
36	18th	36	25th
37	19th	37	26th
38	20th	38	27th

Calculation of 'safe' and 'unsafe' days.

cycle. However, even days 1 to 6 are not foolproof as an unexpectedly early ovulation may result in an unwanted pregnancy.

The method takes a long time to work out, as records for a year, or possibly eight months are needed before you can begin to have intercourse using this method. If you have less than 8 cycles to work with, two imaginary cycles must be added; a short one of 23 days and a long one of 33 days.

The rhythm method should not be relied upon in two cases: firstly in circumstances which might alter the regularity of the cycles, such as physical or emotional disturbances; and secondly if the longest cycle during the past year was more than ten days longer than the shortest, for then the safe period would be extremely short or non-existent.

The time between menstruation and the next ovulation is extremely variable, and it is during this time that one must look for two additional signs, as shown by a doctor, to pinpoint ovulation:

1. Body Temperature

The temperature must be taken by mouth and recorded each morning before getting up, and before taking any hot food or drink. The temperature should be recorded on graph paper. Taken in this way over a month, the temperature runs on a lower level during the first half of the cycle than it does during the second half. Ovulation occurs just before or at the time of the temperature shift from low to high, which normally takes place over not more than 48 hours, and is about ½°C (1°F.) The woman is safe 72 hours after the initial rise in temperature until the next period begins. But of course her temperature may go up for other reasons such as an infection. Special thermometers (with wide markings to make the reading easier) can be bought or ordered from chemists, costing £1.00. Ask for an 'ovulation' thermometer.

2. Mucus

The woman can be taught by her doctor to recognize the changes in the cervical mucus during the menstrual cycle. At the time of ovulation there is an increase in the amount of mucus secreted and it tends to be thinner and can be pulled out in long threads.

Summary

The rhythm method does not enable you to predict when ovulation will occur. It can only be used to calculate when ovulation is most likely to occur, and when it has occurred. A woman can become pregnant when having intercourse during a period, although this is unlikely unless she has long periods and short cycles (21 days or less). Pregnancy cannot occur from 72 hours *after* ovulation until the next period.

Withdrawal (Coitus Interruptus)

Withdrawal is very simple: the couple have intercourse quite normally up to the point of the man's orgasm, when he withdraws his penis before the crucial moment. In theory at least, the semen is shed so that none of it goes into the woman's vagina. Although a lot of people rely on withdrawal and are happy to do so, it is a very unreliable mode of contraception. Ejaculation may take place between the woman's thighs, outside the vagina, and sperm can swim from here to the cervix.

Withdrawal is simple to use, cannot be left behind, and does not require professional supervision; but one quarter of the women relying on it will be pregnant at the end of a year of regular intercourse.

Some considerations

There are probably a few viable sperm in the fluid that escapes before ejaculation. A much greater hazard arises during repeated intercourse when sufficient sperm from the previous intercourse to cause pregnancy, escapes before ejaculation. Withdrawal requires considerable control and seems an unnecessary obstacle to the full enjoyment of intercourse considering that there are effective and easily obtainable methods of contraception. However, it is obviously better than nothing.

Use and Effectiveness of Different Contraceptive Methods

In the table below, the figures for the pregnancy rate represent the number of women out of 100 having regular intercourse who will become unintentionally pregnant in one year, relying on the stated contraceptive method. Thus a figure of 2.0 for the IUD means that in one year 2 out of 100 using the IUD will unintentionally become pregnant.

Method used	*Pregnancy rate*	*Approximate student use**
Combined pill	0.2	30%
Progestogen only pill	3.0	Not known
IUD	2.0	1.5%
Sheath	3.5	40%
Diaphragm (with chemicals)	2.8	1.5%
Chemicals (alone)	15.6	Not known
Withdrawal	15.6	27%
Rhythm	24.0	
No method	80.0	Too many

*These figures are percentages of those students who use any contraceptive method, and are only approximate.

There have been many varying reports of pregnancy rates for different methods. These figures are taken from an ongoing study by the Department of the Regius Professor of Medicine at Oxford. The couples are experienced in the use of contraceptives and are 'highly motivated' to avoid pregnancy.

Contraceptive Summary

	Advantages	*Disadvantages*
Sheaths	1. Easy to obtain at odd hours 2. Can be obtained from friends 3. No medical supervision 4. No side-effects 5. Used only at time of intercourse 6. Protects against VD	1. Need regular stock for frequent intercourse 2. Cost 3. Needs consistent use
Pill	1. Very effective 2. Independent of intercourse 3. Relieves pre-menstrual tension 4. Regulates periods	1. Medical supervision 2. Minor problems 3. Slight chance of major problems 4. Unknown long-term consequences 5. Needs to be taken each day
IUD	1. Effective 2. Independent of intercourse 3. Not taken daily	1. Medical supervision 2. May cause pain and heavy bleeding
Diaphragm with spermicides	1. Good for infrequent intercourse 2. No side-effects 3. Effective if used with care	1. Medical supervision 2. Not independent of intercourse 3. Distasteful and messy for some
Spermicides alone	1. No prescription needed 2. No side-effects	1. Requires careful use 2. Distasteful for some, and messy. 3. Only reasonably effective
Rhythm Method	1. No side-effects 2. Permitted by Roman Catholic Church	1. Not very effective 2. Difficulty of calculations 3. Required abstinence for many days
Withdrawal	1. No supervision 2. No side-effects	1. Unreliable 2. May hinder full enjoyment of intercourse

Further Reading

Sex with Health, the Which? guide to contraceptives, abortion and sex-related diseases, 1974. Published by the Consumers Association and obtainable through them at Consumers Association, Subscription Dept., Caxton Hill, Hertford SG13 7LZ, £1.75.

For its price the most reasonable, comprehensive and up-to-date account of contraceptives available.


Cream
Sheath packet
Diaphragm
Foam tablets
Foam
Foam Applicator
Sheath
Combined Pill

Useless Methods

Douching

Douching is not a means of contraception. If it were to be of any use the douche (washing out of the vagina) would have to be used the moment intercourse was finished – an unpleasant interruption. In any case it is generally a mistake to douche after intercourse in the hope of washing out sperm that have already been deposited. At ejaculation sperm are deposited near the cervix, so that by the time douching occurs, some sperm are already in the uterus and others will be beyond reach of the douching fluid. Douching is also harmful since it destroys protective bacteria in the vagina, and leads to infection by other organisms. No chemical product should be used as a spermicide unless it states clearly and explicitly that it is so designed. Antiseptics and disinfectants are not effective spermicides and they have a drying and irritant effect on the vaginal lining. The advertising about many 'feminine hygiene' products may imply a contraceptive effect, but besides being useless in this capacity many contain coal tar disinfectants which will burn the tissues if not mixed properly. They should never be used.

Sponge Method

A liquid or powder spermicide is put on a small piece of sponge and worked into a foamy consistency. The sponge is then inserted into the vagina near the cervix before intercourse. Not only is it ineffective but it may interfere with intercourse.

Short Rubber Sheaths (American tips)

These sheaths only cover the glans, and grip below the corona. They either slip off or cause constriction, and are not recommended.

Coitus Reservatus (or holding back)

This is the method whereby the man does not even ejaculate at intercourse. No doubt reservatus often turns into interruptus and it is a very frustrating form of contraception which is most unlikely to succeed.

Coitus Saxonicus

As crude as it sounds, it is used far more in erotic literature than real life. In theory you press hard into the man's body near the junction of the urethra and vas deferens just before ejaculation. This is reputed to divert the semen into the bladder instead of through the penis. In practice it is difficult, painful and undesirable.

Contraceptive Fallacies

There are many erroneously held beliefs about contraception which are as amusing as they are useless:

One ancient writer tells the woman to wear a cat's testicle (or that of a weasel, taken alive before the moon went down) across her stomach, preferably in a tube. Even today some women think that they will be safe if they have intercourse standing up, or if they sneeze, cough hard, or hold their breath during the man's orgasm. Others believe that they can stop sperm from getting through by jumping up and down after intercourse – an idea which has even less to recommend it, as it is also exhausting. Unhappily there are also women who believe that they will not conceive if they don't have an orgasm, or if they get up immediately after intercourse and urinate.

Although hot baths and the wrapping of testicles in very warm or tight clothes may reduce the sperm count for a short while, this is not a contraceptive method.

It is possible to become pregnant while breast feeding. To be protected, contraceptives must be used from the first intercourse after pregnancy.

Future Contraceptives

In addition to improvement of already existing methods, we can expect the development of new means of contraception. The methods below are at different developmental stages, and may or may not eventually be widely available.

Depot contraceptives

Injections. Progestogens similar to those in the mini-pill have been tested as long-acting contraceptives, by injections given every 1, 3 or 6 months. The method is effective but irregular bleeding patterns are common.

Capsules. A capsule, from which a progestogen is slowly released, can be placed under the skin to give prolonged contraceptive action. The method has been found to be effective and reversible but often causes irregular bleeding patterns similar to those caused by the mini-pill.

Vaginal Rings. A capsule in the shape of a ring, containing progestogen, can provide effective contraceptive protection when placed in the vagina. The ring is inserted on day 5 of the cycle and removed on day 26 so that normal menstruation can occur. A new ring is inserted for the next month.

IUDs are being developed that slowly release progestogen which has a direct local effect on the womb lining so that implantation cannot occur. This forms an effective contraceptive method and has a promising future.

'Once a month' pills

A long-acting equivalent of the combined pill has proved very effective when taken once a month, although it is less so in the first month of use. The side-effects are similar in frequency and type to those of the daily combined pill

Male Contraceptives

The development of contraceptive pills for the male has never been as intensively studied as for the female. The chief reason has been that until recently research workers have presumed that men would not take a contraceptive pill due to psychological fears about loss of libido. However several drugs have been found to produce reversible male infertility. At present, no drug has been found to be totally satisfactory and extensive research is being carried out to solve this. Recent research suggests that a combined pill, similar in kind to the one produced for women may be a suitable form of male contraception.

Family Planning Clinics

Contraceptive Advice

There are several possible alternatives open to any student seeking contraceptive help. You can go to your College Doctor, or whichever G P you may be registered with. The alternative is the family planning clinic. Many people may be worried about the procedure at clinics so we have outlined this in more detail. Most of the information also applies if a G P is consulted. Advice should be given with complete confidentiality. There are now no charges for advice or any kind of supplies from either G Ps or clinics. Some G P surgeries are now equipped to deal specifically with contraception.

Clinic Procedure

Many people attending a family planning clinic for the first time go with a friend. The clinics encourage both partners to attend, as they feel this may help girls who feel nervous or embarrassed, and also so that both fully understand the pros and cons of the contraceptive method used. Men are NOT able to go to a family planning clinic in Oxford to be supplied with sheaths.

At the reception desk your name is taken – no objection whatsoever being made if you're unmarried, although age and marital status are recorded. Your address, and the name and address of your G P or college doctor are also taken, but he or she is only informed of your registration at the clinic if you are given an IUD or the pill (see below).

A more confidential set of details is taken by a nurse in a separate side room. Weight and blood pressure are recorded and you will be asked if you have had any abortions, miscarriages or VD and whether you have used any previous forms of birth control.

The final consultation is with the doctor, again in complete privacy. She will describe and discuss all the available methods of contraception to ensure that the procedures and implications of each one are fully understood. The method which you then decide is best for you and your partner will be prescribed.

An internal examination is also usually carried out at the first appointment. This is painless and very quick. The size and position of the cervix are checked by insertion of the doctor's finger into the vagina, and also the position and condition of the uterus by pressure on the abdomen from outside. This is just to check that you are not pregnant without realising it, for the pill should not be prescribed if you are. Also, if you have not had intercourse before, it is useful for the doctor to check that the vaginal muscles are not too tense. If they are, and would be likely to cause difficulty on intercourse, she can help you to learn to stretch them. Many people are afraid of the internal examination, or simply find the idea repugnant. There are really no grounds for this and it shouldn't stop you going to a clinic or your doctor for contraceptive advice.

If the cap has been decided on as the contraceptive method it can be fitted now – accurate fitting is necessary as the genital organs vary greatly in size and there is a correspondingly wide range of cap sizes. Fitting of an IUD does not usually take place on the first visit.

A cervical smear may be taken – this is usually done in the first year but may not necessarily be taken on the first visit. In Oxford smears are usually taken once in the under 35 age group. The doctor places an instrument called a speculum inside you to hold the vagina open allowing her to see the walls of the vagina and cervix. This is not usually painful but may be uncomfortable. Using a Q tip swab or spatula, the doctor painlessly wipes some loose tissue from your cervix, on to a glass slide which will be sent to a lab and studied for any signs of developing cancer.

If the pill is to be prescribed, or an IUD fitted a letter will be sent to your doctor informing him of this unless you have strong objections. This information is confidential and your doctor is not entitled to disclose it to anyone except in a law court or to the parents of a girl under 16. Your doctor may have information of which the family planning doctor is not aware and which may be important.

The clinic will provide you with whichever contraceptive you have chosen and these are free. You will have to go back to the clinic every 3 or 6 months to collect supplies, if you are on the pill, and to have regular check-ups of blood pressure and weight. If you have decided on the cap you will have to go back about once every six months to check that it is still the correct size for you, and to obtain supplies of the spermicide you are using with it. If an IUD has been fitted, a first check-up is needed after three months and then a yearly check is all that is required.

It must be stressed that the family planning clinics are not at all concerned with whether you are married or not – they simply want to prevent unwanted pregnancies, and will be helpful and sympathetic without moralizing. They are also ready to help those who have become pregnant – it's never too late to go to the clinic and they will arrange for pregnancy testing. They are also concerned about the emotional aspects of the relationship and are very willing to talk about any difficulties. Many family planning doctors are glad to talk about anything that may be worrying you.

Pregnancy

Despite readily available and reliable contraception, many women find themselves having to deal with an unwanted pregnancy as a result of intercourse with inadequate or non-existent contraception. Perhaps this is due to unplanned intercourse but a high percentage of pregnancies arise through lack of correct information, fear of seeking contraceptive advice or just the belief that 'it will not happen to me'.

1974 was World Population Year, and it is worth considering that, although the birth rate in the UK has been falling for some years, we are overcrowded and the population will soon have an excess of people of high fertility. Each new life here consumes roughly fifty times as much food, steel and other resources as a baby in the developing world, in which half are already malnourished. The *least* we can do is not to create a new life unintentionally.

Nearly one out of every five pregnancies ends in abortion and it is estimated that about one in every four births is initially unwanted. Society is such that life is difficult for the unmarried mother trying to bring up a child on her own, while abortion is still on the borders of legality. Neither problem should arise unless the contraceptive itself fails. Both can be avoided by a visit to your doctor or a family planning clinic, both of whom should treat the visit as confidential. It does mean planning and anticipating intercourse, but enough women conceive the first time they have intercourse to make thinking ahead very necessary.

The probability of pregnancy depends on the fertility of both partners and on the frequency of intercourse. Of 100 women having regular unprotected intercourse for one year, it can be expected that 80 will get pregnant. For both sexes, student age is one of highest fertility and indeed pregnancy is possible without penetration or even without ejaculation, if the penis has been in close contact with the vaginal opening. A few sperm can escape in the lubricating fluid produced by the penis and only one is needed to fertilize an egg.

The Options

For someone who is pregnant, the choices are fairly limited. Studies and career prospects need to be considered by a student: most will want to continue with and complete their course, so the obvious and practical alternative often seems to be an abortion. The alternative is to have the baby and carry on studying. Tutors, principals and doctors will give sympathetic support and help you through the pregnancy as they have helped others in the past.

The choice is never easy especially for those who, for various reasons, feel that they should not have an abortion. This decision is an individual one but uncertainty may often be alleviated by talking about it with someone. For those who are on their own or who just want to discuss their situation with someone else, sympathetic and helpful people can be found at the addresses on p 45. They will be able to give practical advice on fostering or adoption, as well as

information about what public assistance, facilities, and benefits are available if you wish to keep the baby.

The Single Woman's Guide to Pregnancy and Parenthood by Patricia Ashdown-Sharp (Penguin 1975, 95p) covers all you might need to know about abortion, adoption and keeping a child.

Unprotected Intercourse

Morning After Pills (Post-coital Pills)

If unprotected intercourse has occurred which may lead to unplanned and unwanted conception, one possibility to prevent pregnancy is the use of morning after pills.

Taking large doses of oestrogen daily for five days starting within 36 hours of unprotected intercourse appears to be successful in preventing pregnancy. Some women experience severe nausea and vomiting, and there is very often a disturbance of the menstrual cycle. Because oestrogen is being used there is a risk of problems similar to those that occur with the combined pill. As it stands this method is not suitable as a routine contraceptive technique.

Post-coital use of progestogens in low doses also prevents early pregnancy from continuing. In this case there appear to be fewer side-effects, but the method is less effective. Post-coital pills are not widely available, although some doctors may prescribe them. Family planning clinic doctors will probably refer you to the local department of obstetrics and gynaecology.

Suspected Pregnancy

The most obvious and common sign of pregnancy is a missed period, though breast tenderness and nausea may occur before this. Other signs are vomiting, often early in the morning, and bladder irritability causing frequent urination. Pregnancy is not the only cause of missed periods – worry and tension can delay menstruation, especially if a girl fears she might be pregnant after intercourse without contraception.

If you suspect that you might be pregnant, and your period is only up to 3 to 4 weeks overdue a prompt visit to your doctor or family planning clinic can get you referred to the local department of gynaecology, where immediate procedures are available for stopping continuation of pregnancy. One such procedure is the use of drugs known as prostaglandins which induce a period to occur in some, but not all women. The drug is given via the vagina. You will be asked to return to the clinic to confirm whether or not bleeding has occurred. If bleeding has not occurred then a suction process known as vacuum aspiration can be used as an outpatient procedure. In some centres this process is used without confirming pregnancy, and it is known as menstrual regulation/induction. However because the suction method is particularly painful for non-pregnant women, in Oxford it is only used for those who have a positive pregnancy test, or who have a definite likelihood of pregnancy. As such the

method is an early form of abortion. (See page 43) This early form of abortion is preferable if you are certain you wish to have the pregnancy terminated, as it is safer, quicker, and cheaper than later forms of abortion. However it should never be used as a regular form of birth control.

Pregnancy Testing

For anyone who thinks she might be pregnant, a free and reliable pregnancy test can be arranged through your doctor or the family planning clinic. At the clinic, the test, which requires a sample of urine can give a result in a matter of minutes. Tests done within two weeks of the missed period do not give reliable results. By this time the suspected pregnancy would be 6 weeks advanced, as the start of a pregnancy is taken as the first day of the last period. This date is used rather than the time of conception, since the latter is very variable and cannot be accurately determined. For a *very* rough estimate subtract two weeks, e.g. 6 weeks pregnant is roughly equivalent to 4 weeks after actual conception.

Abortion

Unless performed as an outpatient procedure abortions can take up to two weeks to arrange, and as pregnancy cannot be confirmed in less than four weeks from conception (six weeks after the last period), a woman is rarely less than eight weeks pregnant by the time she has the operation. Once the pregnancy is more than twelve weeks advanced, abortion becomes more complicated, more traumatic for the patient, and involves more risk. If a student is going to want an abortion, *promptness is important.*

At present, abortions may be performed in the first 28 weeks of pregnancy, or later if there is dire risk to the life of the mother. It has been recommended that this limit be reduced to 24 weeks.

The best people to approach are your own doctor or a family planning clinic who will probably help to arrange for you to be considered for a free termination under the National Health Service. The strictest confidence is maintained between doctor and patient. If the abortion is obtained through a family planning clinic, everything is also confidential though your G P usually has to be informed, purely for medical reasons. All these people like to see the father as well, because unwanted pregnancy is a problem that should be shared by both partners. Doctors working in student health tend to sympathise with students in this predicament. If they decide you are eligible for a termination under the provisions of the 1967 Abortion Act, then you will be referred to the local hospital.

The first visit there is a preliminary one. The usual procedure is for a doctor to take a medical history and perform a brief physical examination. You will probably be seen by a social worker/counsellor who will talk over any problems with you, especially to make sure you really do want to terminate rather than continue with the pregnancy. They are willing to see you at any time. They will also give information about the termination and the side-effects which might follow it. As after any other operation, depression can be a common sequel to an abortion.

The social workers also arrange for a visit to the hospital family planning clinic soon after the termination. Contraceptive precautions need to be taken as soon as intercourse is resumed, as a further pregnancy can occur almost immediately after the operation.

Registered charities exist to help women who wish to have an abortion. The two main ones are the London Pregnancy Advisory Service and the British Pregnancy Advisory Service. Both do free pregnancy testing but the price of a consultation is £7.50 or £10.00 respectively, which includes a physical examination and counselling services. The charge for an abortion before the twelfth week of pregnancy is £50.00 which includes two nights in a nursing home. Late abortions are more expensive, and are never carried out after the 22nd week: very few are carried out after 20 weeks. Another charitable service is the Brook Advisory Service. Private non-charitable nursing homes prove very expensive.

The Abortion Act

Abortion became legal after the introduction of the 1967 Abortion Act which permits legal abortion if:
1. the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;
2. the continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated;
3. the continuance of the pregnancy would involve risk of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman greather than if the pregnancy were terminated;
4. there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

The conditions can be interpreted liberally or strictly by individual members of the medical profession. If a woman is refused an abortion by a doctor who has conscientious objections, she has the right to be referred to another doctor who does not hold such objections. The signature of two doctors is required by law, the second signature generally coming from the gynaecologist who will carry out the abortion.

The introduction of the Act is thought to have greatly reduced the number of illegal or do-it-yourself abortions. These were often resorted to despite the high risks of infection, haemorrhage and even death. Since abortion became legal, abortion deaths have dropped by half and are still on the decline.

Home methods of procuring an abortion are dangerous and usually unsuccessful in terms of inducing a miscarriage. Nature protects the foetus very well and hot baths, jumping from heights, drinking gin and taking various drugs and herbs will not dislodge it. Supposed past 'successes' would probably have ended in a miscarriage anyway. Douching with lethal liquids such as paraffin or the insertion of sharp objects into the womb (knitting needles, crochet hooks, pencils, scissors, hairpins have all been tried) are exceedingly dangerous and are likely to cause haemorrhage, perforation and permanent damage to the cervix or uterus. These singularly nasty methods are as likely to kill the mother as the foetus – or lead to subsequent infertility.

The Operative Procedures

The operation can be undertaken as an outpatient procedure by vacuum aspiration during the first three or four weeks after the missed period. This process involves sucking out the contents of the womb.

Vacuum aspiration is carried out with the woman lying on her back, with her legs supported in the air by stirrups, which makes the procedure for the doctor very much easier. A small tube connected to a vacuum pump is passed into the womb, and is rotated around for 20 to 30 seconds sucking out any contents. The procedure can be painful, so a local anaesthetic is used.

The suction method has some degree of complication as it is not altogether free

of the risk of infection, and it does not terminate pregnancy in a small percentage of women. It causes a minimum amount of bleeding. Vacuum aspiration is safe to use up to three months of pregnancy, but after the first four weeks it is carried out under general anaesthesia, and an overnight stay in hospital is required.

Short-term risks of abortion are infection or bleeding. After twelve weeks of pregnancy the risks involved are substantially increased because the abortion techniques are more complicated. For the majority of these abortions prostaglandins are again used, and these cause the womb to expel the foetus as in normal childbirth. Prostaglandins are injected into the womb either via the vagina or through the skin. Schedules of injections differ, but a typical procedure is to give an injection in the evening with the abortion occurring some fifteen hours later. The majority of women need stay in hospital for no more than 2 days. Most women have some bleeding for the following few weeks, and menstruation normally starts again within six weeks.

Check-ups following any abortion are always necessary to ensure there are no complications or worrying side-effects, and it is *essential* that anyone who has had an abortion should go back. Patients are also likely to be seen again by the counsellor, mainly to ensure their psychological well-being. If a reliable contraceptive was not used before the abortion *now is the time to obtain and use effective contraception so that a further unwanted pregnancy does not occur.*

Conclusion.

No contraceptive method is one hundred per cent reliable and pregnancies can still occur due to contraceptive failure; an abortion service is thus a necessary complement to an efficient family planning service. However, if would be very undesirable for women to rely on abortion as a form of birth control. Compared with contraception, abortion is an expensive procedure, and very demanding of hospital resources. Repeated abortion carries with it an increased risk to health and subsequent capabilities of bearing children.

Further Reading

Abortion: the personal dilemma by R. F. R. Gardner. Paternoster Press 1972, £1.40.
A Christian gynaecologist thoroughly examines the medical, social and spiritual issues concerned with abortion. Extensive referencing.

Abortion Law Reformed by K. Hindell and M. Simms. Peter Owen 1971, £3.25.
An account of the fight to reform the law.

Useful Addresses

British Pregnancy Advisory Service
Head Office: Austy Manor, Wootton Wawen, Warwicks.
☎ Henley-in-Arden 3225

Branches in Birmingham (☎ 021-643-1461), Coventry, Manchester, Liverpool, Brighton, Leeds, Bedford, Bournemouth, Trowbridge.

Brook Advisory Centre 233 Tottenham Court Road, London W1P 9AE
☎ 01-323-1522

Contraceptive advice, pregnancy testing and abortion counselling.
Branches in Birmingham, Bristol, Cambridge, Coventry, Edinburgh and Liverpool.

Grapevine 296 Holloway Road, London N7 ☎ 01-607-0935
Sexual problems, abortion, contraception.

Help 79 Buckingham Palace Road, London SW1 ☎ 01-828-7495
10 South Wharf Road, London W2 ☎ 01-402-5233
Abortion help and free pregnancy testing.

London Pregnancy Advisory Service 40 Margaret Street, London W1
☎ 01-409-0281

London Youth Advisory Centre 31 Nottingham Place, London W1
☎ 01-935-1219

26 Prince of Wales Road, London N5
☎ 01-267-4792

Margaret Pyke Centre 27 Mortimer Street, London W1A 4QW
☎ 01-580-3077
Complete contraceptive service.

Marie Stopes Memorial Centre 108 Whitfield Street, London W1
☎ 01-388-0662
Contraceptive advice, pregnancy testing and abortion counselling.

National Council for One-parent Families 255 Kentish Town Road, London NW5
☎ 01-267-1361

Sterilization

Sterilization deserves mention simply because it is becoming an increasingly popular method of birth control, even though it is only applicable to couples who are committed to having no more children. This section is purely for general information, as no student would be sterilized, except for very convincing medical reasons. At present it has to be regarded as irreversible, though in the future temporary sterilization may become the most efficient and reliable form of birth control.

Vasectomy

This is a very simple and quick operation which can be performed under a local anaesthetic as an out-patient procedure. The operation is usually free from complications in a healthy patient and most can return to work shortly afterwards.

The operation involves making a small incision in the scrotum (on both sides) and a small length of the vas deferens is cut out. The two free ends are then tied or sealed off by cautery, stopping sperm from passing through. Since sperm comprise very little of the total volume of ejaculatory fluid, no change in this amount should be noticed. Sterilization is not immediate as it takes a while for sperm to disappear from the ejaculate. Thus contraceptive precautions need to be taken until two sperm-free specimens of semen have been tested by a doctor.

Vasectomy *per se* does not reduce a man's ability to have an erection and orgasm.

Tubal Ligation

This is the simplest technique of female sterilization. Other methods such as hysterectomy (removal of the womb) are not used in this country unless the womb is diseased.

The principle of the operation is the same as vasectomy: the Fallopian tubes are cut so that eggs released from the ovaries cannot pass to the uterus. Compared to vasectomy, tubal ligation is a more serious operation. It takes longer, requires more medical skill, and involves a short stay in hospital. There is also a low but measurable mortality rate because a general anaesthetic is used and the abdominal cavity is opened.

Conclusion

Neither vasectomy or tubal ligation will produce changes in the levels of sex hormones in the body. Women continue to produce eggs and have periods and men continue to produce sperm. These simply degenerate and are reabsorbed into the body. The ability to enjoy sex is in no way affected and contraceptive protection can almost always be guaranteed.

Sex-related Diseases

Urethritis and Cystitis in Women

Urethritis is any inflammation of the urethra, and this is often followed by cystitis, which is inflammation of the bladder. Urethritis is very common, and can be extremely unpleasant. There is a frequent desire to urinate, with a burning pain on doing so, as well as continuous discomfort. It can be caused in a number of ways, including bacterial infection. This can spread to the kidneys and cause permanent damage, so it is important to go to your doctor immediately. A urine sample is necessary to confirm diagnosis, and if bacteria are detected a course of antibiotics will be prescribed, usually providing a complete cure. The bacteria usually get into the urethra with moisture from the vagina or anus: if possible, it is best to avoid rubbing anything into the urethra. If there is a tendency for urethritis to recur it can be helpful to urinate after intercourse to wash away anything that may have got into the urethra. Drinking large quantities of water will alleviate the symptoms and help clear away the infection.

There is an organisation called the U and I Club, founded by an ex-cystitis sufferer to help women cope with chronic cystitis and vaginal infections:–
U and I Club 22 Gerrard Road, London N1 8AY ☎ 01-359-0403.

Candidiasis ('Thrush')

This is caused by a yeast fungus that is present in up to 20 per cent of women, but only produces symptoms in perhaps one per cent. The symptoms are usually itching of the vagina and vulva, and sometimes a whitish discharge: the itching is often worse at night. The fungus can be caught through genital contact. Men can catch it and carry it under their foreskin, often showing no symptoms; if there are symptoms these are usually irritation under the foreskin or at the tip of the penis, and sometimes a discharge is present. Anal infection is possible. Diagnosis can be accurately made using tests and microscope examinations taken on a swab. Treatment with ointments, pessaries and occasionally pills provides complete cure.

Sexually Transmissible Diseases

With the changes in social behaviour and decrease in the use of the sheath as a method of contraception the incidence of sexually transmissible diseases is reaching epidemic levels in some places. In 1974 over 1000 students were treated for sexually transmissible complaints in Oxford. However much of the prejudice caused by the fear and ignorance of sexually transmissible diseases has been dispelled by the introduction of venereology (VD or special) clinics in most British hospitals.

An often unappreciated aspect of sexually transmissible diseases is that they are frequently symptomless, especially in women. A recent survey showed that 1,639 people became infected from just one source. It is vital that people should know who their contacts are, and also co-operate with the trained personnel at the VD clinic. They, with the patient's consent, will discreetly contact anyone whom the patient does not wish to approach personally. Contact tracing is now widely regarded as the strongest weapon against sexually transmissible diseases.

The Clinic and the Surgery

Anyone who suspects he might have a sexually transmissible disease has two main alternatives. A general practice has the advantages of privacy and convenience, (most college doctors have considerable experience of sexually transmitted diseases), but cannot usually offer the highly efficient contact tracing staff of an NHS Clinic.

Treatment by a G P will vary in form, but there is a routine at the hospital clinics. No appointment is necessary, but it is often advisable to find out whether one is preferred. At the clinic the patient's history is taken, for statistical purposes, and then there is a private consultation with a doctor.

There are both male and female doctors, and they will arrange for certain routine tests to be performed, some of which may irritate, but none of which are found to be unacceptable by patients. Small samples are taken from potentially diseased areas, and a urine specimen is usually required. A blood test for syphilis is also routinely performed.

A cervical smear may be taken if a woman has not had such a check-up. The results of most of the tests are known immediately, but some require laboratory facilities and it is several days before the results are available.

In teaching hospitals such as the Radcliffe Infirmary, medical students may also be present. If the patient so wishes, they can be asked to leave.

Treatment is usually prescribed immediately after diagnosis, and a follow-up programme is also organized. At this stage either the doctor or a trained assistant

will discuss the situation with the patient, and every effort is made to determine the infective source (primary contact) and those to whom the disease may have been passed (secondary contacts). The staff of the clinic will then trace these people, or will give the patient a 'contact slip' to send to each contact, who should then take his or her slip to any venereology clinic in the country. This is part of a nationwide service designed to provide swift and convenient treatment for all.

Unfortunately, although a high percentage of the secondary contacts receive treatment, comparatively few primary contacts are successfully traced and it is here that the patient's co-operation is of most help. It should be stressed again that any tracing is done *only* with the full consent of the patient.

At most special clinics there is a psychiatric social worker who will provide advice and help to anyone with practical or emotional problems.

Finally it should be said that in most venereology clinics the staff are friendly and uncritical. In the words of one postgraduate: 'I've been to several VD clinics and they're the friendliest clinics I've been to.'

1. Gonorrhoea (The 'Clap')

The incidence of gonorrhoea in England is increasing rapidly, accounting for almost 30% of all the sexually transmitted diseases.
The disease is caused by a bacterium which is a strictly human parasite, and dies rapidly outside the conditions of the genital region. Thus gonorrhoea *cannot* be caught from toilet seats, and is only transmitted by close genital contact, as are almost all the sexually transmitted diseases listed here. The bacteria can also survive in the mouth, where they may cause gonorrhoeal sore throat, or there may be no symptoms.

Once transmitted, gonorrhoea usually takes 2 to 4 days to become recognizable in men, although some may not notice the symptoms for as long as three weeks. Women on the other hand are often *without symptoms*, and up to 70% may remain so.

In the man, the main symptom is that of urethritis – painful inflammation of the urethra. It hurts to urinate, and a discharge may be seen from the urethral opening at the tip of the penis – a green or yellow liquid, which may be blood-stained. This discharge is most apparent in the morning, before urination. Most women have a certain amount of vaginal discharge all their lives, but the discharge may alter upon onset of the disease, and there may be discomfort and inflammation of the vaginal entrance or of the whole vaginal region. Another common sign, also present in women, is the frequent passage of small quantities of urine. In both women and men, infection of the anus can also occur – causing inflammation, soreness and possibly some discharge.

Gonorrhoea is infectious whenever the bacteria are present, so cure is essential. The treatment consists of a course of antibiotics, usually in tablet form, which eliminates the bacteria but does not confer immunity – gonorrhoea may be caught again and again. If left untreated there are several possible complications, the most serious of which is sterility.

2. Non-specific Genital Infection (Non-specific urethritis, NSU)

This is the commonest sexually transmissible disease, although its causes are still debated. It is said to occur occasionally in a couple without a third person introducing it. In the main it affects men; up to 80% of women will remain without symptoms; one of the reasons for the recent dramatic increase in the number of cases of this disease.

The symptoms are similar to those of gonorrhoea – urethritis and some urethral discharge. Women may have some vaginal irritation and discharge. Treatment of NSU consists of a course of antibiotics (tablets) and full cure is likely; in some cases however, the disease will recur without new infection, but this trouble usually ceases with time.

3. Syphilis (The 'Pox', 'Bad Blood')

This is the most dangerous of the sexually transmissible diseases, and in its late stages can be fatal. Fortunately it has a low incidence in England, and now, with antenatal care, congenital syphilis is very rare. In Oxford there were only 18 new cases in 1974 out of a total of 4,000 cases of sexually transmissible diseases. A large proportion of the cases occur among homosexuals.

The disease is conventionally divided into three stages. The primary stage includes the symptoms which always occur within 9 to 90 days of infection: a spot appears at the site of original infection. This will spread out into a sore which may be up to the size of a fingernail. This usually occurs on the genitals; in men most often on the glans penis or near the frenulum, or occasionally on the shaft of the penis or in the pubic hair. Women are usually infected on the labia, in the vagina, or on the cervix: the primary sore may pass unnoticed, as it causes no pain in either sex.

In both sexes the primary sore may occur in or near the anus, or anywhere in the mouth, if these parts have been in contact with an infected area. The sore usually disappears after 3-8 weeks but the disease remains infectious for up to four years. The secondary phase marks the spreading of the organism throughout the body in the blood stream, and may show itself by fever, headache, skin rashes, swollen glands and occasionally loss of hair. It may last for many years and may take a variety of forms. In the third stage the infection involves the large blood vessels and the brain, leading to severe headaches, general paralysis and death.

Syphilis can be accurately diagnosed at any stage with the correct tests, and treatment (usually a course of injections) almost invariably provides a complete cure in the early stages before permanent damage is done. It should be realized that not all sores of the genital region are syphilitic, and that it may well take 20 years for the third stage of syphilis to occur.

4. Trichomoniasis

This disease is common in women and occurs occasionally in men. As the organism can survive for a while in damp conditions, it could be caught from places such as lavatory seats. The symptoms in women are vaginal discomfort and itching of the labia, accompanied at times by pain on urination. The skin of the genital region can become extremely sore and chapped. In men urethritis may occur but most men have no symptoms.

Diagnosis can be made accurately on examination of vaginal or urethral swabs, and a complete cure can be achieved by taking a course of tablets. These are usually prescribed for the regular partner as well as for the women to prevent re-infection.

5. Genital Herpes

This is caused by a virus similar to that causing cold sores, and it may occur in symptom-free forms. When a woman first becomes infected she usually feels very ill with flu-like symptoms, and she usually has intense pain in the vulva and vagina. Swelling of the glands in the groin and general malaise are usual in the male. After 3-4 weeks the illness settles, but can recur in both men and women.

The virus can be killed in the first infection, provided the patient is seen soon enough. Expert help is needed, for if treatment is delayed recurrences are very common.

6. Candidiasis ('Thrush')

This is covered in 'Sex-related Diseases'.

7. Other Sexually Transmissible Diseases

These include genital warts, scabies, pubic lice ('crabs'), Lymphogranuloma Venereum (LGV) and chancroid. The last two diseases are much rarer in England than in tropical countries. All can be cured with the correct treatment.

Scabies is caused by a mite, the female of which lays its eggs in the skin and then dies. In due course the eggs hatch: a rash is caused and sometimes the minute tracks made by the young mite may be seen in the skin.

Lice feed on skin and blood. They attach themselves to hairs of the genital region -- the legs are suitably spaced for the louse to grab on to and swing along two adjacent pubic hairs and lay eggs, 'nits', attached to these hairs. These can be seen, as can the lice which are about the size of a match head. It is now believed that they may be carriers of gonorrhoea. The main symptom is itching, which may be mild or severe. Treatment is by lotions, usually a solution of DDT derivative which may only need one application and does not involve shaving the pubic hair. As the animal dies when away from the

warmth of the body, infested clothes should be left hung up for a couple of days. Sexual intercourse is not always necessary for transmission of these parasites, as close personal contact may suffice.

Although it is not possible simply to list the diseases and their diagnostic symptoms, urethritis, urethral discharge and painless sores in the male and urethritis, abnormal discharge and genital irritation as well as painless sores in the female, are reasons for expert consultation. On no account should self-treatment be undertaken, as it is usually ineffective and can actually make the diseases worse.

With the correct treatment all sexually transmissible diseases are curable.

Further Reading

Venereal Diseases by Dr. R. S. Morton. Penguin 1972, 40p.
A thorough book covering medical and social aspects of VD.

VD explained by Dr. R. Stratham. Care and Welfare Library Series, Priory Press 1972, 80p.
Simpler; covers all the diseases and is written for a wide readership.

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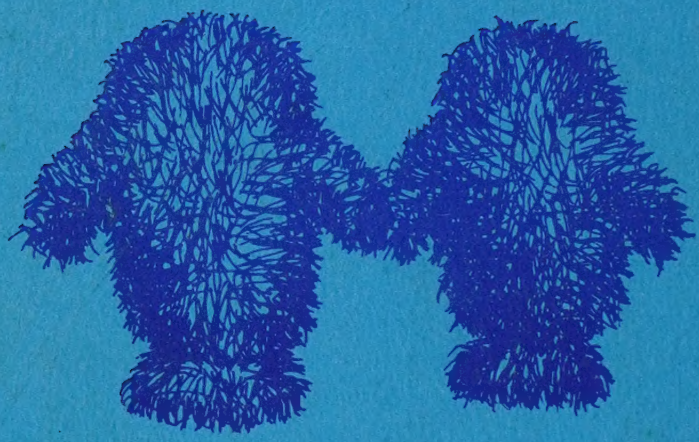

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